<u>REQUIRED HEALTH FORMS CHECKLIST FOR RETURNING STUDENTS</u>

*Please return this packet to CRMS by **July 15, 2010** ALL FORMS MUST BE COMPLETED BEFORE ARRIVING AT CRMS.*

_____Permission for Medical Care and Authorization for Release of Information/General Information Form

Students may not go on Wilderness or attend any active programs without this form completed.

_____Private Insurance Coverage Information Form

Please include a copy of the front and the back of your insurance card. <u>Cut out and paste</u> the copy on the form.

_____Physical Examination Form

*This form is required **<u>EACH</u>** year for all CRMS students. It must be completed by a non-parent physician **<u>BEFORE</u>** any participation in active or Wilderness. It is absolutely necessary to get a physical before arriving at CRMS. **Please do not expect your student to be able to get a physical upon their arrival here**.*

_____Permission for Influenza Vaccine and Consent for Medications Form

The CRMS Health Office offers flu shots once each year. If you want your student to have a flu shot please make sure you sign this form.

_____Permission for Prescribed Medication Form

If your student is taking any prescribed medications, this form must be filled out by the prescribing doctor. All prescribed medications must be kept in the CRMS Health Office unless an agreement has been made between the school nurse and parent. This is school policy.

_____Roaring Fork Family Physicians Forms

*Please make sure this form is filled out **<u>completely</u>**. If your student is sick and in need of medical care, this form is necessary. Please do not wait until your child needs to be seen to fill this form out. Roaring Fork Family Physicians requires it for EACH student EACH year.*

_____Notice of Privacy Policy

A hard copy of our privacy policy can be found on our website, crms.org.

Permission for Medical Care and Authorization for Release of Information

***ALL** forms **MUST** be fully completed, signed and returned to the Colorado Rocky Mountain School Health Office by July 15th in order to avoid any delays in your student's registration and for your child to participate in the Active Program. This includes all school activities and trips.*

I hereby give consent to Colorado Rocky Mountain School, or other instructional support staff associated with but not limited to Colorado Rocky Mountain School, to carry out accepted procedures for diagnosis, immunization, medical and surgical treatment, or counseling for my son/daughter/ward,

____

Please Print! *Student's name: First* *Middle* *Last*

(In rare instances a medical, surgical, or psychiatric emergency arises in which a written consent by the parent or guardian is legally required, but the proper person cannot be located. In such circumstances, in order to avoid delay which might jeopardize the life or recovery of a student, we also request the following permission from the parents or guardian, with the understanding that every effort will be made to contact them in an emergency.) I hereby grant permission to Colorado Rocky Mountain School, and other health care providers, including but not limited to Roaring Fork Family Physicians, Snowmass Clinic, Valley View Hospital, Aspen Valley Hospital, or if on a school trip, the nearest hospital emergency room to give medical care, emergency care, necessary anesthesia, and perform necessary surgery on my son/daughter/ward. I hereby grant permission to Colorado Rocky Mountain School and/or necessary medical personnel to have access to my son/daughter/ward's medical record in the event of admission to a medical facility. I hereby authorize the Colorado Rocky Mountain School Health Office who have provided health care services to my son/daughter/ward to release medical information (including information related to drug/alcohol treatment), as required to carry out treatment, health care operations, and payment, unless more specific authorization is required by law. I also authorize other health care providers who have provided medical treatment or related services to my son/daughter/ward, including, but not limited to Colorado Rocky Mountain School, to release medical information (including information related to drug/alcohol treatment) to the medical facility deemed necessary to carry out treatment and health care operations, unless more specific authorization is required by law. I authorize the release of medical information to my insurance company as may be necessary to determine benefits entitlement and to process payment claims for health care services rendered. When parents are separated or divorced, absent a court order to the contrary, Colorado Rocky Mountain School presumes that a non-custodial parent has access to health information and input to the same extent as a custodial parent. *My signature below indicates my consent to the above matters. This consent will remain in effect throughout the 2010-2011 school year unless it is revoked by me or my son/daughter/ward's other parent or guardian.*

______________________ ______________________ __________

SIGNATURE OF PARENT/GUARDIAN SIGNATURE OF STUDENT DATE

PHARMACY PAYMENT:

I hereby authorize payment from my son/daughter/ward's Colorado Rocky Mountain School bookstore account to cover the pharmacy cost, designated by Colorado Rocky Mountain School, of any co-payments or unpaid balances after insurance, for medications provided to my child.

______________________ __________

SIGNATURE OF PARENT/GUARDIAN DATE

General Information

Please Print

Student's Name ____ Grade_______
(Please print) *First* *Middle* *Last*

Social Security # ____________________________ Date of Birth ____/____/____ Male __ Female___
(MM/DD/YYYY)

Parent's Information

All information is needed in case of an emergency!

Father's Name ____________________________ Mother's Name ____________________________

Address __________________________________ Address __________________________________
No. *Street* *No.* *Street*

__________________________________ __________________________________
City/Town *State* *Zip Code* *Country* *City/Town* *State* *Zip Code* *Country*

Home Phone (___) __________________________ Home Phone (___) __________________________

Work Phone (___) __________________________ Work Phone (___) __________________________

Cell Phone (___) __________________________ Cell Phone (___) __________________________

Social Security # __________________________ Social Security # __________________________

Birth Date (MM/DD/YY)___________________ Birth Date ________________________________

Email____________________________________ Email____________________________________

Parents are: Married ___ Divorced ___ Separated ___

If parents are living apart, with whom does the student live? ____________________________________

Please list below two individuals who may take full responsibility for this student in the event neither parent can be reached.

Name __________________________________ Name__________________________________

Relationship ____________________________ Relationship____________________________

Address ________________________________ Address ________________________________
No. *Street* *No.* *Street*

__________________________________ __________________________________
City/Town *State* *Zip Code* *Country* *City/Town* *State* *Zip Code* *Country*

Home Phone (____)________________________ Home Phone (___)________________________

Work Phone (____) ________________________ Work Phone (___)________________________

PRIVATE INSURANCE COVERAGE INFORMATION

CRMS students are required to have health insurance coverage. For more information, visit our website.

Student Name: ____________________________Social Security No: _______________________

Insurance Company Name: ____

Identification No.:____________________________ Group No.:____________________________

Address: __________________________________City: _________________________________

State: ______ Zip: ___________ Phone: ___________________ Fax: ________________________

Policyholder Last Name: _________________________First Name & Initial: __________________

Social Security No.: ____________________________ D.O.B.:________________________

Relationship to Student: __________________Policyholder Employer: _______________________

Prescription Coverage: Yes_______ No________

Does your insurance require pre-authorization? YES________ NO________

Please notify the Colorado Rocky Mountain School Health Office should there be any changes in your insurance plan or coverage.

PRIVATE INSURANCE AND PRESCRIPTION BENEFIT CARDS

Please make a clear copy of the front and back of your insurance card and prescription benefit card, cut them out, and attach them below.

PHYSICAL EXAMINATION
TO BE COMPLETED BY PHYSICIAN

*(This is required for ALL students **each** year and must be completed before arrival at CRMS)*

Student Name ____ Sex: M__ F __ D.O.B.: ___/___/___
(MM/DD/YYYY)

Height____________ | Hearing ~ Right________ Left ________
Weight____________ | Vision ~ Uncorrected Right________
Blood Pressure______ | Left_________
Pulse______________ | ~ Corrected Right________
Left_________

Are the following systems normal?	Yes	No	Abnormal findings
Skin			
Head, Eyes			
Ears, Nose, Throat			
Thyroid, Lymph nodes			
Chest/Lungs			
Breasts			
Heart			
Abdomen			
Genitourinary			
Hernia			
Back/Extremities			
Neurological			
Psychological			

Are there any significant medical problems not noted above? If yes, please describe:
____

TB test result from this physical or date of negative result within last year _________________
Date of last Tetanus shot ___________ (if not within last 10 years, immunize now and write today's date)

Please list all prescribed Medications____
____

Please list all medication allergies/reactions____
____

Food allergies/reactions ____
____

Is there any reason to restrict physical activities? ____

Do you recommend any further evaluation or therapy? ____

Physician/ARNP/PA Signature: ____

Address: _________________________________ Telephone: _____________________ Date: _________

Colorado Rocky
Mountain School
est. 1953

PERMISSION FOR INFLUENZA VACCINE AND CONSENT FOR MEDICATIONS

Student Name: ____
Please Print

Permission for Influenza Vaccine

HIGHLY RECOMMENDED DUE TO RESIDENTIAL NATURE OF THE INSTITUTION

My son/daughter/ward____
Please Print Students Name

Please check one of the following

_____Has my permission to receive influenza vaccines for seasonal flu or other types of influenza.

_____Does NOT have my permission to receive the influenza vaccine.

____ _______________
Signature of Parent/Guardian *Date*

Consent for Medications

I, _______________________________________, hereby give consent on this ____ day of
Parent's Name (please print) *Date*
______________________________, 20___, for the Colorado Rocky Mountain School Health
Month *Year*
Office and residence hall staff (after Health Office hours) to dispense standing order medications (Tylenol, Ibuprofen, and other basic over the counter remedies) on an as needed basis for acute illnesses and/or injuries to:

____, for the 2010-2011 school year.
Student's Name (please print)

____
Parent Signature

Permission Form for Prescribed Medication

Colorado Rocky Mountain School Health Office
1493 County Road 106
Carbondale, Colorado 81623
970-963-2562, ext. 150 / fax 970-963-9865

PLEASE MAKE COPIES AND FILL OUT A NEW FORM FOR EACH MEDICATION!

Student Name: ____

→ ***To be completed by the physician or authorized prescriber***

Name of medication: ____

Medication indication: ____

Form of medication/ treatment:

_____ Tablet/ capsule _____Liquid _____ Inhaler _____Injection _____Nebulizer _____Other

Instructions (schedule and dosage to be given at school): ____

____

Start: ☐ date form received other date: _______________________

Stop: ☐ end of school year other date/duration: ________________

OR: ☐ PRN

Restrictions and important side effects: ☐ None anticipated

☐ Yes, please describe: ____

____

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other

Please add any pertinent additional information:

Date: ________________ Prescriber's Signature: ____

Physician's Name:
Address:
Phone Number:
Email:

→ ***To be completed by parent/guardian***

I have read and understand the Colorado Rocky Mountain School medication policy. I give permission for (Name of child) ______________________________ to receive the above medication at Colorado Rocky Mountain School according to school policy.

Date: ________________ Signature: _________________________________ Relationship: _________________________

ROARING FORK FAMILY PHYSICIANS, P.C.
1340 HWY 133, CARBONDALE C0 81623
PHONE: 970-963-3350 FAX: 970-963-2958
E-MAIL: rffpmedrec@vvh.org

May 2010

Dear CRMS Parents:

Our Family Practice group has provided care for CRMS students since 1977. For the 2010-2011 school year, we are requiring the following payment procedure:

1. **A CREDIT CARD (VISA, MASTER CARD OR DISCOVER) must be on file before your child will be seen. WE DO NOT ACCEPT AMERICAN EXPRESS.**

    a. Fill out the credit card information on the registration form, attached.

    b. YOUR CREDIT CARD WILL BE CHARGED FOR FULL AMOUNT OF SERVICES RENDERED EACH TIME YOUR CHILD IS SEEN FOR A VISIT.

2. **INSURANCE:** See attached registration form for insurance information.
ENCLOSE A COPY OF THE FRONT AND BACK OF STUDENT'S INSURANCE CARD.

WE DO NOT BILL FOR PATIENT SERVICES; THEREFORE, IF A CREDIT CARD IS NOT ON FILE WITH OUR OFFICE, ALTERNATIVE ARRANGEMENTS WILL NEED TO BE MADE PRIOR TO YOUR CHILD BEING SEEN.

If you have any questions, please call me and I will be glad to assist you.

Sincerely,

Keri Murphy
Administrative Assistant
Phone: 970-963-3561, Ext. 200
FAX: 970-963-2958
e-mail: rffpmedrec@vvh.org

REGISTRATION FORM
ROARING FORK FAMILY PHYSICIANS
COLORADO ROCKY MOUNTAIN SCHOOL–PATIENT REGISTRATION FORM

STUDENT'S FULL NAME:____ **SEX**: MALE FEMALE

DATE OF BIRTH:_____________________________SOCIAL SEC. #: ____________________

DATE OF LAST TETANUS SHOT__________ ALLERGIES_______________________________

STUDENT'S CELL PHONE:____

ONGOING MEDICATIONS____

RESPONSIBLE PARTY--PARENT/GUARDIAN

FATHER'S NAME:_____________________________HOME PHONE #:____________________

ADDRESS:__________________________________CELL PHONE#:________________________

____WORK PHONE #:______________________

E-MAIL ADDRESS:____

MOTHER'S NAME:____________________________HOME PHONE #:____________________

ADDRESS:___________________________________CELL PHONE#:______________________

____WORK PHONE #:_______________________

E-MAIL ADDRESS:____

A Credit Card **(VISA, MASTER CARD OR DISCOVER)** must be on file before your child will be seen.
(WE DO NOT ACCEPT AMERICAN EXPRESS!!!)

Your credit card will be charged for full amount of services rendered each time your child is seen for a visit.

CARDHOLDER: NAME: ___________________________**CREDIT CARD#**__________________

EXPIRATION DATE: __________________**3 DIGIT V-CODE ON BACK OF CARD**_____________

SIGNATURE OF CARDHOLDER:_____________________________________
INSURANCE: ENCLOSE A COPY OF THE FRONT AND BACK OF THE STUDENT'S INSURANCE CARD showing policy number and mailing address for claims. We will file insurance for you and any remainder will be billed to your credit card unless other arrangements are made in advance. All charges will be considered out of network and no discounts given, unless you belong to Aetna, Cofinity, Cigna, Great West Health Care, Rocky Mountain Health Plans, Blue Cross/Blue Shield or United Health Care/Pacificare. For billing questions please contact Susie at scheney@rffpdocs.com.

WE DO NOT BILL FOR PATIENT SERVICES; THEREFORE, IF A CREDIT CARD IS NOT ON FILE WITH OUR OFFICE, ALTERNATIVE ARRANGEMENTS WILL NEED TO BE MADE PRIOR TO YOUR CHILD BEING SEEN.

POLICY HOLDER'S NAME:_____________________SOCIAL SECURITY #___________________

POLICY HOLDER'S DATE OF BIRTH:_________________

RETURN TO:
ROARING FORK FAMILY PHYSICIANS, P.C.
1340 STATE HWY. 133, CARBONDALE, CO 81623
(ATTENTION--Keri)

Phone: 970-963-3561, Ext. 203
Fax: 970-963-2958
E-Mail: rffpmedrec@vvh.org

<u>Colorado Rocky Mountain School</u>

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I_________________________________
Parent's name
acknowledge having access to and reading a complete copy of the Notice of Privacy Practices on the CRMS website. This privacy notice is effective as of April 14, 2003. If you have any questions about the information in the Notice or would like to obtain a hard copy of the notice, please call the Health Office at 970-963-2562 ext. 150. Thank you.

_____________________________ __________
Signature of Parent or Guardian *Date*

_____________________________ __________
Signature of CRMS Student *Date*

<u>PLEASE RETURN THIS PAGE TO THE CRMS HEALTH OFFICE</u>